Restitution To The Plan (continued)

You or your dependent must cooperate with the plan and its agents, and must sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of reimbursement. You or your dependent must also provide any relevant information, and take such actions as the plan or its agents reasonably request to assist the plan in making a full recovery of the reasonable value of the benefits provided. You or your dependent must not take any action that prejudices the plan's right of reimbursement. The plan may reduce or deny future benefits on the basis that you or your dependents have refused to sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of reimbursement.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the *plan administrator*, in the exercise of its sole discretion.

Subrogation

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent for your or your dependent's *illness* or *injury* and the plan has paid benefits related to that *illness* or *injury*. This section is not an imposition of personal liability, but reflects the equitable right of the plan to restore plan assets to the plan for the benefit of all participants. The actions of another party caused the plan to incur expenses it would not normally have incurred, therefore the plan is entitled to pursue any cause of action or pursue any remedy available to you or your dependents (regardless of how that action may be characterized and regardless of whether you or your dependent have been made whole).

The plan is subrogated to all of the rights of you or your dependent against any party liable for your or your dependent's *illness* or *injury* to the extent of the reasonable value of the benefits provided to you or your dependent under the plan. The plan may assert this right independently of you or your dependent.

You or your dependent are obligated to cooperate with the plan and its agents in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim, and obtaining the consent of the plan or its agents before releasing any party from liability for payment of medical expenses.

If you or your dependent enter into litigation or settlement negotiations regarding the obligations of other parties, you or your dependent must not prejudice, in any way, the subrogation rights of the plan under this section. Please see the "Restitution To The Plan" section above regarding yours or your dependent's obligations regarding any compensation received or constructively received.

The costs of legal representation of the plan in matters related to subrogation will be borne solely by the plan. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

Right To Receive And Release Necessary Information

The plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement plan provisions, including medical information. When you request benefits, you must either furnish or authorize the release of all the information required to implement plan provisions. Your failure to fully cooperate will result in a denial of the requested benefits and the plan will have no further liability for such benefits.

Recovery Of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this plan, the plan has the right to recover these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the plan will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

Alternate Payee Provision

Under normal conditions, all benefits payable by the plan to a *PPO* provider are payable to the provider of services or supplies. All other benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The plan must make payments to your separated/divorced spouse, state child support agencies or *Medicaid* agencies if required by a qualified medical child support order (QMCSO) or state *Medicaid* law.

The plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the plan.

Any payment made by the plan in accordance with this provision will fully release the plan of its liability to you.

Reliance On Documents And Information

Information required by the *plan administrator* may be provided in any form or document that the *plan administrator* considers acceptable and reliable. The *plan administrator* relies on the information provided by you and others when evaluating coverage and benefits under the plan. All such information, therefore, must be accurate, truthful and complete. The *plan administrator* is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to the *plan administrator*. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the plan.

No Waiver

The failure of the *plan administrator* to enforce strictly any term or provision of this plan will not be construed as a waiver of such term or provision. The *plan administrator* reserves the right to enforce strictly any term or provision of this plan at any time.

Physician/Patient Relationship

This plan is not intended to disturb the *physician*/patient relationship. *Physicians* and other *health care providers* are not agents or delegates of the *employer*, *plan administrator* or the third party *contract administrator*. Nothing contained in this plan will require you or your dependent to commence or continue medical treatment by a particular provider. Further, nothing in this plan will limit or otherwise restrict a *physician's* judgment with respect to the *physician's* ultimate responsibility for patient care in the provision of medical services to you or your dependent.

Plan Is Not A Contract Of Employment

Nothing contained in this plan will be construed as a contract or condition of employment between the *employer* and any employee. All employees are subject to discharge to the same extent as if this plan had never been adopted.

Additional Information On Covered And Excluded Benefits

If you would like to receive additional information regarding a specific drug, medical test, device or procedure which is either a covered or excluded benefit under this plan, you may contact First Health at 1-800-541-1623, or via the Internet by logging on to www.firsthealth.com and entering your access ID: **CBK**.

Right To Amend Or Terminate Plan

The *plan administrator* reserves the right to amend, modify or terminate the plan in any manner, for any reason, at any time.

FILING A CLAIM FOR PAYMENT OF BENEFITS

Your *health care provider* should file claims for you. Electronically submitted claims are processed most efficiently. If unable to file electronically, your *health care provider* may submit the following:

- HCFA-1500 or UB-92 forms for medical expenses; and
- prescription submittal forms.

These are the only appropriate forms for requesting plan payment. If your *health care provider* is unable to file one of these forms for you, you are responsible for completing and submitting it. These forms are available from either your *health care provider* or *employer*. Include the following information:

- employee's name, Social Security number and address;
- patient's name, Social Security number and address if different from the employee's;
- *health care provider's* name, tax identification number, address, degree and signature;
- date(s) of service;
- diagnosis;
- procedure codes (describes the treatment or services rendered);
- assignment of benefits, signed (if payment is to be made to the provider);
- release of information statement, signed;
- explanation of benefits (EOB) information if another plan is the primary payor.

You should submit claims for each individual. Please do not attach or staple claims together. If additional information is needed to process your claim or the claim of your dependent, you or your *health care provider* will be notified. If you receive a letter regarding your claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim. The claim will be denied for lack of necessary information if the information requested in the letter is not supplied within 45 days. If you submit the requested information after the 45-day period, this will be treated as a new submission of the claim.

Send complete information to:

First Health Benefits Administrators Corp.
P.O. Box 8400
London, KY 40742

FILING A CLAIM FOR PAYMENT OF BENEFITS (continued)

The plan will provide you with notice of the claim determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This time period will be delayed, if the plan requests additional information, until the requested information is received by the plan. The plan may also request a 15-day extension if matters beyond its control require the extension and notice is provided to you within the 30-day period.

If you have any questions regarding your claim, please call: 1-800-541-1623.

All claims must be received by the plan within a 12-month period from the date of the expense.

HOW TO APPEAL A DENIAL OF BENEFITS OR CLINICAL NON-CERTIFICATION

To request a clarification of a benefit determination or clinical certification recommendation, you or your *authorized representative* may always call the *contract administrator* at the toll-free number on the back of your identification card, or submit the request by logging on to www.firsthealth.com and using the My **First Health**® feature. However, if you believe a *claim denial* or clinical non-certification was improper, the following processes are available:

Oral Appeal

For an oral appeal of a clinical non-certification for a *request for certification involving urgent care*, please call 1-800-541-1623. Oral appeals will only be accepted for this type of *claim denial.*

Written Appeal

Within 180 days of receipt of the notice of the *claim denial* or clinical non-certification, you may request, in writing, that the plan conduct a review of the processed claim. However, for an appeal of a clinical non-certification of a *request for certification involving urgent care*, you or your *health care provider* may appeal verbally. All requests for a review of *claim denial* or clinical non-certification should include a copy of the initial denial letter and any other relevant information (e.g. written comments, documents, articles or records). Any discrepancies between a benefit description in the plan document and the way a claim was processed will be corrected promptly. The *contract administrator* will provide all relevant information to the *plan administrator*. Upon receipt of the appeal information from the *contract administrator*, the *plan administrator* will:

1. Review all comments, documents, records, and other information submitted by you;

2. Consult with an appropriate health care professional if the claim was denied because it was not considered *medically necessary,* or the service was considered *investigational/experimental.* You may request the name of the health care professional who was consulted;

3. Request additional information necessary to review the appeal. You should provide the information as soon as possible;

4. Use discretionary authority in making an appeal determination, however, such discretionary authority will be consistent with determinations for similarly situated plan participants; and

5. Provide notice of the appeal determination in writing, or orally, where appropriate.

Send all written information to the *contract administrator*:

First Health Benefits Administrators Corp.
P.O. Box 8400
London, KY 40742

Requests for appeal which do not comply with these procedures will not be considered, except in extraordinary circumstances. You will be notified if the appeal request has not been considered and you will be allowed to present evidence of why the appeal should be considered.

Written Appeal (continued)

Because claims filing periods and appeals periods may overlap, the plan will coordinate appeals of clinical non-certifications, claims for payment of benefits and appeals of claims for payment of benefits. If you submit an appeal for a clinical non-certification but have already received the services which are the subject of the appeal, and First Health has received a claim for benefits while the appeal is under consideration, the appeal will be reviewed as follows:

1. The appeal will be consolidated and all submitted information will be taken into consideration when the claim for benefits is reviewed. A notice of claim determination will be provided. If the claim for benefits is denied, you may file a final appeal of the *claim denial*; and

2. If the claim for benefits was already denied prior to your submitting the appeal of a clinical non-certification, the plan will consider this your appeal of the claim for benefits denial.

The *plan administrator* will notify you of the final decision within a reasonable time period, but not later than:

1. 72 hours for an oral appeal of a clinical non-certification for a *request for certification involving urgent care*;

2. 30 days for all appeals of a clinical non-certification which are not considered to fall under No. 1 above;

3. 60 days for all other appeals.

Time Period For Filing Legal Actions

No action at law or in equity shall be brought to recover under this plan until the appeal procedures of this plan have been exhausted with respect to the claim, nor (unless applicable state law permits a longer period) will any action be brought unless within 2 years from the expiration of the time within which proof of loss is required to be furnished under this plan.

OPTIONAL CONTINUATION OF COVERAGE

This section explains continuation coverage, when it may become available to you and your eligible dependents, and what you need to do to protect the right to receive it. Continuation coverage is the same coverage that the plan gives to other participants or beneficiaries under the plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights.

Continuation Of Coverage Under Federal Law (COBRA)

As mandated by federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, otherwise known as COBRA), the plan offers optional continuation coverage to you and/or your dependents if coverage of the eligible beneficiary would otherwise end due to one of the following qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and your eligible dependents.
- A reduction in hours worked by you. Coverage may continue for you and your eligible dependents.
- Your death. Coverage may continue for your eligible dependents.
- Divorce or legal separation from your spouse. Coverage may continue for that spouse and your other eligible dependents.
- You become entitled to *Medicare* (Part A, Part B or both). Coverage may continue for eligible dependents who are not entitled to *Medicare*.
- Loss of eligibility of a covered dependent child. Coverage may continue for that dependent.
- Your *employer* files a Title 11 bankruptcy petition. Coverage may continue for retirees and their beneficiaries if the plan covers such retirees and beneficiaries within one year of the date of the bankruptcy petition and if such retiree coverage ends or is substantially reduced within one year before or after the filing for bankruptcy. (Please note that the plan may not cover retirees, in which case *employer* bankruptcy is not a qualifying event.)

NOTE: To choose this continuation coverage, an individual must be a covered person under the plan on the day before the qualifying event. You can also obtain continuation coverage for children born to, adopted by or placed for adoption with you during the period of your continuation coverage if they are timely enrolled under the terms of the plan. In the case of bankruptcy, an individual must have retired on or before the date coverage was substantially reduced, or be a beneficiary of the retired employee on the day before the bankruptcy.

Notification Requirement

You or other qualifying individual(s) have the responsibility to inform the *plan administrator* of a divorce, legal separation or a child losing dependent status under the Christopher & Banks, Inc. Comprehensive Major Medical Plan within 60 days of the qualifying event or, if later, the date coverage under the plan would end. You must provide this information in writing to the person or department listed at the end of this section. Please include documents that verify the change, such as a divorce decree or separation papers. Failure to provide this notification within 60 days will result in the loss of continuation coverage rights.

Your *employer* has the responsibility of notifying the *plan administrator* of your death, termination of employment, reduction in hours, entitlement to *Medicare* or the *employer's* bankruptcy within 30 days of the qualifying event.

The plan will notify you and other qualifying individual(s) of continuation coverage rights within 14 days of its receipt of the notice described above. Each qualifying individual will have an independent right to elect COBRA continuation coverage. You and any other qualifying individuals will then have 60 days to elect continuation coverage. Failure to elect continuation coverage within 60 days after being notified by the *plan administrator* (or, if later, the date coverage under the plan would end) will result in loss of continuation coverage rights.

Maximum Period Of Continuation Coverage

The maximum period of continuation coverage for individuals who qualify due to termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

If a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours, or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled family members who are also entitled to continuation coverage may be extended to 29 months. The qualifying individual or family member, if applicable, must notify the *plan administrator* within the 18-month continuation coverage period and within 60 days after receiving notification of disability. You must provide this notice of information to the person or department listed at the end of this section. You must also provide notice within 30 days of the date the same qualifying individual is subsequently determined by the Social Security Administration to no longer be disabled.

The maximum period of continuation coverage for individuals who qualify due to any qualifying event other than termination of employment, reduction in hours or bankruptcy, is 36 months from the date of the qualifying event, subject to the following requirements:

If an individual experiences more than one qualifying event, the maximum period of coverage will be computed from the date of the earliest qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event. Notice must be provided to the plan within 60 days of the date the second qualifying event occurs, and the extension will only occur if the second qualifying event would have caused the individual to lose coverage under the plan had the first qualifying event not occurred.

Maximum Period Of Continuation Coverage (continued)

If within 18 months of the date continuation coverage begins you became entitled to *Medicare* or have a qualifying event that would not result in a loss of coverage if you were an active employee, your covered spouse and dependent children will only be entitled to 18 months of continuation coverage from the date of the first qualifying event, or 29 months in the case of disability.

Qualifying retirees who retired before bankruptcy are entitled to continuation coverage for life, unless coverage would end as otherwise noted in this section. In this situation, the retiree's eligible dependent spouse and children are also entitled to continuation coverage until the earlier of: the dependent spouse's or child's death; or 36 months after the retiree's death. This only applies if the retiree's coverage previously allowed dependent coverage.

Cost Of Continuation Coverage

The cost of continuation coverage is determined by your *employer* and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the plan's cost of coverage.

You and other qualified individual(s) must make the first payment within 45 days of notifying the plan of selection of continuation coverage. Future payments can be made in monthly installments within 30 days of the due date unless your *employer* establishes a longer payment schedule. Rates and payment schedules are established by your *employer* and may change when necessary due to plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

- The date the maximum continuation period expires.
- The date the qualifying individual becomes entitled to coverage under *Medicare*, if the *Medicare* entitlement date is after the date that the individual elected continuation coverage.
- The last period for which payment was made when coverage is canceled due to non-payment of the required cost.
- The date the *employer* no longer offers a group health plan to any of its employees.
- The date the qualifying individual becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.

Special Additional Continuation Coverage Election Period For "TAA-Eligible Individuals"

In addition to the other COBRA rules described above, there are some special rules that apply if you are classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.) The *plan administrator* will require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, federal income tax filings, etc. The plan need not require every available document to establish evidence of TAA eligibility. You will be responsible for providing evidence of TAA eligibility when applying for coverage under the plan. The plan will not be required to assist you in gathering such evidence.

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than 6 months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this notice, your coverage period will be measured from the date of your TAA-related loss of coverage. For example:

> If you lose coverage on January 1, 2006 because your job is transferred out of the country, you will be eligible to make a continuation coverage election within 60 days of your loss of coverage and your coverage would be available for up to 18 months beginning on the date you lose coverage. However, if you do not elect continuation coverage during that period and the Department of Labor classifies you as a TAA-eligible individual on May 30, you will qualify for a second election period, lasting from May 1 through June 30. If you elect coverage during that period, your coverage will be effective retroactive to May 1, and you will be entitled to coverage for the remainder of your continuation coverage period measured from the time you actually lost coverage, so your coverage will be available until June 30, 2007 (18 months after January 1, 2006) unless the period is cut short or extended for one of the reasons described above.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some of your expenses for continuation coverage. You should consult with a financial advisor if you have questions about the tax credit.

TAA Coverage and HIPAA Creditable Coverage

If you are a TAA-eligible individual who elects COBRA after becoming TAA eligible, the period beginning on the date of the TAA-related loss of coverage and ending on the first day of the TAA-related election period will be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the plan's pre-existing condition provision.

Applicable Premium Payments

Payments of any portion of the applicable COBRA premium by the federal government on behalf of a TAA-eligible individual pursuant to TAA will be treated as a payment to the plan. Where the balance of any premium owed the plan by such individual is determined to be significantly less than the required applicable premium, as explained in IRS regulations 54.4980B-8, A-5 (b), the plan will notify such individual of the deficient payment and permit 30 days to make full payment. Otherwise the plan will return such deficient payment to the individual and coverage will terminate as of the original premium due date.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the person or department listed at the end of this section. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the *plan administrator* informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the *plan administrator*.

Plan Contact Information

Benefits Supervisor
Christopher & Banks, Inc.
2400 Xenium Lane North
Plymouth, MN 55441
(763) 551-5000

DEFINITIONS

The following terms define specific wording used in this plan. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of this plan.

Accident (Accidental)

An unforeseen and unavoidable event resulting in an *injury*.

Actively At Work (Active Employment)

You are considered to be actively at work when performing in the customary manner all of the regular duties of your occupation with the *employer*, either at one of the *employer's* regular places of business or at some location to which the *employer's* business requires you to travel to perform your regular duties or other duties assigned by your *employer*. You are also considered to be actively at work on each day of a regular paid vacation or non-working day, but only if you are performing in the customary manner all of the regular duties of your occupation with the *employer* on the immediately preceding regularly scheduled work day.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; supply registered professional nursing services whenever a patient is in the facility; and be *Medicare* approved or accredited as an ambulatory surgical facility by the Joint Commission on Accreditation of Healthcare Organizations.

Authorized Representative

A person authorized by you to act on your behalf with regard to requests for certification and claims. You will be considered an authorized representative for all your dependents, without a written request, unless the plan is notified otherwise, or the dependent is the subject of a QMCSO. For certification requests, a *health care provider* with knowledge of your or your dependent's condition will be considered an authorized representative. All other authorizations must be in writing and signed by you. You should include this with any claims.

Benefit Year

The 12-month period beginning December 1 and ending November 30. All annual deductibles and benefit maximums accumulate during the benefit year.

Birthing Center

A public or private facility, other than private offices or clinics of *physicians*, which meets the free-standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: a facility which has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one specialist in obstetrics and gynecology; a *physician* or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least 2 beds or 2 birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; and the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for emergency transfers and maintain medical records on each patient and child.

Chiropractic Services

The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claim Denial

A denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit. The basis for the determination of the denial, reduction or termination of, or failure to provide or make payment (in whole or in part) includes, but is not limited to: (a) your or your dependent's eligibility to participate in the plan; (b) the application of any prior notification requirements; or (c) the plan specifically does not cover the item or service, or considers the item or service to be *investigational/experimental* or not *medically necessary*.

Contract Administrator

First Health Benefits Administrators Corp. has been hired as the third party contract administrator by the *plan administrator* to perform claims processing and other specified administrative services in relation to the plan. The contract administrator is not an insurer of health benefits under this plan, is not a fiduciary of the plan and does not exercise any of the discretionary authority and responsibility granted to the *plan administrator*. The contract administrator is not responsible for plan financing and does not guarantee the availability of benefits under this plan.

Cosmetic Surgery

A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an *illness* or *injury*.

Custodial Care

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Domestic Partner

An individual who meets all of the following criteria:

1. Be united in a long-term, committed relationship (for at least 1 year) and intend to remain together indefinitely;
2. Be unmarried and have no other domestic partners;
3. Not be related to you by blood to an extent which would prohibit a legal marriage in the state in which you legally reside;
4. Share a residence;
5. Be at least 18 years of age and have the capacity to enter into a contract; and
6. Submit any required proof of partnership as outlined below.

Any two of the following items, for current and 12 months trailing must be submitted as proof of domestic partnership with the application:

1. Joint bank account
2. Joint lease/mortgage of mutual residence
3. Joint credit card accounts
4. Joint loan agreement
5. Joint ownership of property
6. Joint billing statements: such as gas, electric, telephone, etc.

Diagnostic Charges

Charges for x-ray or laboratory examinations made or ordered by a *physician* or *practitioner* in order to detect a medical condition.

Durable Medical Equipment

Equipment able to withstand repeated use for the therapeutic treatment of an active *illness* or *injury*. Such equipment will not be covered under the plan if it could be useful to a person in the absence of an *illness* or *injury* and could be purchased without a *physician's* prescription.

Employer

Christopher & Banks, Inc. together with its parent and subsidiaries.

Enrollment Date

The earlier of the first day of coverage or, if there is a waiting period, the first day of the waiting period. For late enrollees, the enrollment date is the first day of coverage.

Health Care Provider

A *physician*, *practitioner*, *nurse*, *hospital* or *specialized treatment facility* as those terms are specifically defined in this section.

Home Health Care Agency

A public or private agency or organization, licensed and operated according to the law, that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group; at least one *physician* and one registered graduate nurse to supervise the services provided; and be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Home Hospice

A program, licensed and operated according to the law, which is approved by the attending *physician* to provide palliative, supportive and other related care in the home for a covered person diagnosed as terminally ill.

Hospice Facility

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive and other related care for a covered person diagnosed as terminally ill.

The facility must have an interdisciplinary medical team consisting of at least one *physician*, one registered nurse, one social worker, one volunteer and a volunteer program. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A hospice facility is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital

A public or private facility, licensed and operated according to the law, which provides care and treatment by *physicians* and *nurses* at the patient's expense of an *illness* or *injury* through medical, surgical and diagnostic facilities on its premises.

The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A hospital does not include a facility or any part thereof which is, other than by coincidence, a place for rest, the aged or convalescent care.

Illness

Any bodily sickness, disease or *mental/nervous disorder*.

Injury

A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or *accident*.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A section, ward or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate nurses or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Investigational/Experimental

A health product or service is deemed experimental if one or more of the following criteria are met:

- Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing;
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in *peer-reviewed medical literature*.

Legend

Any drug that requires a prescription from either a *physician* or a *practitioner*, under either federal or applicable state law, in order to be dispensed.

Lifetime

The period of time you or your eligible dependents participate in this plan or any other plan sponsored by Christopher & Banks, Inc.

Maintenance Care

Services and supplies provided primarily to maintain a level of physical or mental function.

Medicaid

Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Emergency

A sudden, serious, unexpected and acute onset of an *illness* or *injury* where a delay in treatment could cause irreversible deterioration resulting in a threat to the patient's life or a body part, or an organ not returning to full, normal function.

Such conditions include, but are not limited to, suspected heart attack or stroke, loss of consciousness, actual or suspected acute poisoning, acute appendicitis, toxicity due to drugs or alcohol, acute renal failure, heat exhaustion, convulsive disorder, severe hemorrhage/allergic reaction, airway obstruction or aspiration, emergency medical care rendered for an *accidental injury* and other acute conditions.

Medically Necessary (Medical Necessity)

Medically necessary services and/or supplies the *plan administrator* determines, in the exercise of its discretion, to be:

1. Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin;

2. Necessary to meet the basic health needs of the patient as a minimum requirement;

3. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;

4. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by the plan;

5. Consistent with the diagnosis of the condition;

6. Required for reasons other than the comfort or convenience of the patient or his or her *physician*; and,

7. Of demonstrated value based on clinical evidence reported by peer reviewed medical literature and by generally recognized academic medical experts; that is, it is not *investigational/ experimental*.

A treatment, procedure, service or supply must meet all of the criteria listed above to be considered medically necessary and to be eligible for coverage under this plan. In addition, the fact that a *health care provider* has prescribed, ordered or recommended a treatment, procedure, service or supply does not, in itself, mean that it is medically necessary as defined above.

Medicare

Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Mental/Nervous Disorder

For purposes of this plan, a mental/nervous disorder is any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), except as specified in Medical Expenses Not Covered, for which treatment is commonly sought from a psychiatrist or mental health provider. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by mental health professionals. Diagnoses described in the DSM will be considered mental/nervous in nature, regardless of etiology.

Mental/Nervous Treatment Facility

A public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation and effective treatment of *mental/nervous disorders*; and professional nursing services provided by licensed practical nurses who are directed by a full-time R.N. The facility must also have a *physician* on staff or on call.

The facility must prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Morbid Obesity

A diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction, and conventional weight reduction measures have failed.

Body mass index (BMI) is calculated from your weight in kilograms divided by your height in meters squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254. Contact your *physician* to determine if you meet this definition.

Nurse

A person acting within the scope of his/her license and holding the degree of Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

Oral Surgery

Necessary procedures for *surgery* in the oral cavity, including pre- and post-operative care.

Outpatient

Treatment either outside of a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Partial Hospitalization

A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a *mental/nervous disorder* when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric *nurses* and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a *physician.*

Peer-Reviewed Medical Literature

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-reviewed literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

Physically Or Mentally Handicapped

The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator

The plan administrator, Christopher & Banks, Inc., is the sole fiduciary of the plan, and exercises all discretionary authority and control over the administration of the plan and the management and disposition of plan assets. The plan administrator shall have the sole discretionary authority to determine eligibility for plan benefits or to construe the terms of the plan, and benefits under the plan will be paid only if the plan administrator decides, in its discretion, that the participant or beneficiary is entitled to such benefits.

The plan administrator has the right to amend, modify or terminate the plan in any manner, at any time, regardless of the health status of any plan participant or beneficiary

The plan administrator may hire someone to perform claims processing and other specified services in relation to the plan. Any such contractor will not be a fiduciary of the plan and will not exercise any of the discretionary authority and responsibility granted to the plan administrator, as described above.

Plan Sponsor

Christopher & Banks, Inc.

Plan Year

The 12-month fiscal period for Christopher & Banks, Inc. beginning December 1 and ending November 30.

Practitioner

A *physician* or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist, Occupational Therapist, Physician's Assistant, Registered Respiratory Therapist, Nurse Practitioner, Licensed Professional Counselor (L.P.C.) or Licensed Clinical Psychologist (L.C.P.).

Preferred Provider Organization (PPO)

The **First Health**® Network, including those *health care providers* who have contracted to provide certain services for which benefits are considered at special levels.

Psychiatric Day Treatment Facility

A public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than 8 hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a *physician* certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Healthcare Organizations, or be *Medicare* approved.

Reconstructive Surgery

A procedure performed to restore the anatomy and/or functions of the body which are lost or impaired.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part-time care services, or an institution which primarily provides treatment of *mental/nervous disorders*, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, *Medicare* approved, or is accredited as such a facility by the Joint Commission for the Accreditation of Healthcare Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Request For Certification Involving Urgent Care

Any request for certification of proposed services to which the application of the time periods for making non-urgent care certifications: (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (2) in the opinion of a *physician* with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Residential Treatment Facility

A residential treatment facility provides 24-hour, subacute care for children, adolescents or adults. The facility must be licensed by the state as a health care facility and accredited for residential treatment by the Joint Commission for the Accreditation of Healthcare Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

The treatment must be directed by a health care *practitioner*, licensed for independent practice in the state, who evaluates and treats the patient no less frequently than weekly and who meets directly with the treatment team on a regular, scheduled basis. Individual, group and family psychotherapy must be provided by licensed mental health *practitioners* or, in the case of chemical dependency, certified chemical dependency counselors.

Second Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility

A public or private facility, licensed and operated according to the law, which provides: permanent and full-time facilities for 10 or more resident patients; a registered nurse or *physician* on full-time duty in charge of patient care; at least one registered nurse or licensed practical nurse on duty at all times; a daily medical record for each patient; transfer arrangements with a *hospital*; and a utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their *illness* or *injury*, and is not, other than by coincidence, a rest home for *custodial care* or for the aged. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Specialized Treatment Facility

Specialized treatment facilities as the term relates to this plan include *birthing centers, ambulatory surgical facilities, hospice facilities, skilled nursing facilities, mental/nervous treatment facilities, substance abuse treatment facilities, psychiatric day treatment facilities,* chemical dependency/ substance abuse day treatment facilities, *residential treatment facilities, rehabilitation facilities* and *urgent care treatment facilities* as those terms are specifically listed in Covered Medical Expenses.

Substance Abuse Treatment Facility

A public or private facility, licensed and operated according to the law, which provides: a program for diagnosis, evaluation and effective treatment of substance abuse; detoxification services; and professional nursing services provided by licensed practical nurses who are directed by a full-time R.N. The facility also must have a *physician* on staff or on call.

The facility must prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. The facility must also be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Surgery

Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision.

Third Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

Urgent Care Facility

A public or private facility, licensed and operated according to applicable state law, where ambulatory patients can receive immediate, non-emergency care for mild to moderate *injuries* and/or *illnesses* without scheduling an appointment.

Usual And Customary Charge (U&C)

The charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other *physicians* or *practitioners*. U&C does not apply to providers participating in the *PPO* or MultiPlan network.

Year

See *benefit year*.

RIGHTS OF PLAN PARTICIPANTS

As a participant in Christopher & Banks, Inc. Comprehensive Major Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

1. Examine, without charge, at the *plan administrator's* office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration).

2. Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The *plan administrator* is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your *enrollment date* in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your *employer*, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the *plan administrator* to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *plan administrator*. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the *plan administrator*. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the *plan administrator*, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR PRIVACY RIGHTS

As a participant in the Christopher & Banks, Inc. Comprehensive Major Medical Plan (the "Plan"), you are entitled to certain rights concerning your protected health information under the Health Insurance Portability and Accountability Act (HIPAA). The following describes how health information about you may be used and disclosed and how you may access this information.

The Plan is permitted to make certain types of uses and disclosures of protected health information under applicable law for treatment, payment and health care operations purposes.

Use And Disclosure Of Information To And From Christopher & Banks, Inc.

The Plan may disclose protected health information to Christopher & Banks, Inc. (the "*plan sponsor*") under limited circumstances. The Plan will disclose protected health information to the *plan sponsor* only upon receipt of a certification by the *plan sponsor* that the plan documents have been amended to incorporate and to abide by these privacy provisions.

The Plan may disclose summary health information to the *plan sponsor* for the purposes of obtaining premium bids, insurance coverage, or modifying, amending or terminating the Plan.

The Plan may disclose protected health information to carry out plan administration functions that are consistent under applicable law. The Plan may not disclose protected health information to the *plan sponsor* for the purpose of employment-related actions or decisions or in connection with other benefits or employee benefit plans of the *plan sponsor*.

A limited number of employees of the *plan sponsor* will have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business. These employees are in the following areas: VP Human Resources, Human Resource Manager, Benefit Coordinator and Benefits Supervisor.

These employees will only use protected health information for plan administration functions, consistent with the plan's Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, other applicable federal or state privacy law and the departments' privacy policies. Should an employee of the *plan sponsor* not comply with the plan's Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, or other federal or state privacy law, the employee will be subject to corrective action. The *plan sponsor* will promptly implement the contingency plans to mitigate any deleterious effect of improper use or disclosure of protected health information by Christopher & Banks, Inc. employees or by the Plan's business associates.

Use And Disclosure Of Information To And From Christopher & Banks, Inc. (continued)

If feasible, the *plan sponsor* must return or destroy all protected health information received from the Plan that the *plan sponsor* maintains in any form. The *plan sponsor* cannot retain copies of such information when it is no longer needed for the purpose for which disclosure was made. If the return or destruction of protected health information is not feasible, the *plan sponsor* will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. The *plan sponsor* has an obligation under the law to retain records for its plan administrative functions, and will retain the required records, which may or may not contain protected health information as required under the law. The *plan sponsor* must report to the Plan any use or disclosure of protected information that is inconsistent with the uses or disclosures provided for of which the *plan sponsor* becomes aware.

The *plan sponsor* must make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the Standards for Privacy of Individually Identifiable Health Information.

Use And Disclosure Of Health Information By The Plan

The Plan will not use or disclose protected health information other than as permitted or required by the plan documents or as required by law. For instance, the Plan is permitted to disclose minimum necessary protected health information without your authorization for public health activities, health oversight activities, research and judicial and administrative proceedings. The Plan is permitted to disclose protected health information to law enforcement officials as required by law. The Plan is also required to disclose protected health information to you or your personal representative to the extent you have a right of access to the information and to the U.S. Department of Health and Human Services on request for complaint investigation or compliance review.

The Plan's business associates are permitted to use protected health information received from the Plan for the specific activities for which those business associates are contracted. Before receiving your protected health information, the Plan's business associates must agree to the same restrictions and conditions that apply to the Plan and *plan sponsor* under the Standards for Privacy of Individually Identifiable Health Information and other applicable federal or state privacy laws. The *contract administrator* is considered a business associate of the Plan.

Access, Amendment And Accounting Of Health Information

You have a right to request access to inspect and obtain a copy of your protected health information that the Plan and the Plan's business associates maintain in a designated record set. The Plan has established procedures in its Privacy Policies and Procedures to grant access to your protected health information. The Plan has a right to deny your request for access, and you have the right to request a review of that denial under certain circumstances, pursuant to the provisions of 45 CFR § 164.524. The designated record set that the Plan maintains includes documentation about enrollment, payment, claims adjudication, or case/medical management. To request access to your protected health information, please contact your Benefits Supervisor.

Access, Amendment And Accounting Of Health Information (continued)

You have a right to request the Plan amend your protected health information that the Plan and the Plan's business associates maintain in a designated record set. The Plan has established procedures in its Privacy Policies and Procedures to allow amendment to your protected health information. The Plan has a right to deny your request for amendment, and you have the right to attach a statement of disagreement, pursuant to the provisions of 45 CFR § 164.526. To request an amendment to your protected health information, please contact your Benefits Supervisor.

Pursuant to 45 CFR § 164.528, you have a right to request an accounting of disclosures of your protected health information made by the Plan six years prior to the date on which the accounting is requested, beginning with the effective date of the Standards for Privacy of Individually Identifiable Health Information, which is April 14, 2003.

> **Example 1**: You request an accounting on September 14, 2003. The Plan is obligated to account for disclosures made from April 14, 2003 through September 14, 2003.
>
> **Example 2**: You request an accounting on September 14, 2010. The Plan is obligated to account for disclosures made from September 14, 2004 through September 14, 2010.

The Plan does not have to account for disclosures made:

- to you;
- to carry out treatment, payment and health care operations;
- pursuant to your authorization;
- incident to a use or disclosure otherwise permitted under the Standards for Privacy of Individually Identifiable Health Information;
- for national security or intelligence purposes;
- as part of a limited data set;
- occurred prior to April 14, 2003; or
- for other reasons listed in 45 CFR § 164.528.

To request an accounting of disclosures of your protected health information, please contact your Benefits Supervisor.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan at Human Resources, Christopher & Banks, Inc., 2400 Xenium Lane North, Plymouth, MN 55441, 1-763-551-5000. You also may complain to the Secretary of the Department of Health and Human Services at Hubert H. Humphrey Building, 200 Independence Ave. SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Your Health Information And Privacy

Your health information is confidential, and your privacy will be protected. Medical information obtained through administrative services, including medical claims and pharmacy claims, may be used to help identify the appropriate level of Care Support, Case Management or other programs available to you as described in the plan. You may receive prescription drug refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your health information also may be used for quality assessment and improvement activities related to your medical benefits. Medical information obtained through these administrative services will not be used to make employment and personnel decisions.

Note: The following terms as used in this section are defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164): "protected health information," "summary health information," "business associates," "personal representative," "designated record set," and "limited data set."

Security

On April 21, 2005, the final rule implementing the Security Standards ("Security Rule") under the Health Insurance Portability and Accountability Act of 1996 will be effective. To comply with the Security Rule, the *plan sponsor* must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that it creates, receives, maintains or transmits. The Plan's business associates must agree to implement reasonable and appropriate security measures to protect health information received from the Plan or *plan sponsor*. A limited number of employees of the *plan sponsor* will have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business, and there are reasonable and appropriate security measures in place to ensure that only these employees will have access to information. The *plan sponsor* will report to the Plan any security incident of which it becomes aware.

GENERAL INFORMATION

Type Of Plan

A welfare plan providing group medical and prescription drug benefits.

Name And Address Of The *Plan Sponsor*

Human Resources
Christopher & Banks, Inc.
2400 Xenium Lane North
Plymouth, MN 55441
(763) 551-5000

Name And Address Of The *Plan Administrator*

Human Resources
Christopher & Banks, Inc.
2400 Xenium Lane North
Plymouth, MN 55441
(763) 551-5000

Name And Address Of The Designated Agent For Service Of Legal Process

Human Resources
Christopher & Banks, Inc.
2400 Xenium Lane North
Plymouth, MN 55441
(763) 551-5000

Name And Address Of The Third Party *Contract Administrator*

First Health Benefits Administrators Corp.
P.O. Box 8400
London, KY 40742

Internal Revenue Service And Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 41-0851237. The plan number is 501.

Plan Year

The *plan year* is the 12-month fiscal period for Christopher & Banks, Inc. beginning December 1 and ending November 30.

Method Of Funding Benefits

Health benefits are self-funded from accumulated assets and are provided directly from the *plan sponsor*. The *plan sponsor* may purchase excess risk insurance coverage which is intended to reimburse the *plan sponsor* for certain losses incurred and paid under the plan by the *plan sponsor*. Such excess risk coverage, if any, is not part of the plan.

The total level of funding will be determined by the aggregate stoploss policy, taking into consideration the number of employees covered each month. Contribution rates will also be determined in this manner.

Payments out of the plan to *health care providers* on behalf of the covered person will be based on the provisions of the plan.